COMMONWEALTH CARE ALLIANCE (CCA) PROVIDER CONTRACT REQUEST/INITIATION FORM

Please complete all applicable sections of this form and return to CCAContracting@commonwealthcare.org

Organization/Practice Name:	
Legal Name:	
Tax ID:	**Organization NPI:**
Phone:	**Fax:**
Primary Address: *If you have additional locations, please attach site location list with form.*	
Counties Served (Please check all appropriate boxes for the area that you service):	
☐ Providence ☐ Kent ☐ Newport ☐ Bristol ☐ Washington ☐ Other (Please Explain):	

Provider Type/Specialty:	
☐ Acute Care Hospital	☐ Long Term Acute Care Facility
☐ Adult Day Health	☐ Orthotics and Prosthetics
☐ Adult Foster Care	☐ Outpatient Behavioral Health
☐ Assisted Living	☐ Outpatient Dialysis
☐ Certified Home Health Agency	☐ Peer Support, Counseling, Navigation
☐ Day Habilitation	☐ Primary Care
☐ Day Services	☐ Rehabilitation Facility
☐ Durable Medical Equipment	☐ Skilled Nursing Facility
☐ Group Adult Foster Care	☐ Physician Specialty (please specify) _____
☐ Home Care Services	☐ Substance Abuse Treatment
☐ Hospice	☐ Vision Care
☐ Laboratory	☐ Other (please specify)_____
Please note any specific capabilities or services that set you apart from other similar providers:	

Licensure/Certifications			
License Type (DPH, DMH, etc.)		License Number:	
Medicare Certified?	☐ Y ☐ N	Certification Number:	
Medicaid Certified?	☐ Y ☐ N	Certification Number:	
Accredited/Certified?	☐ Y ☐ N	Accreditation/Certifying Agency:	

Signature Authority:	Date: